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SMALLPOX IN NOTTINGHAM, ENGLAND, IN 1921.¹

Prior to February 16, 1921, no case of smallpox had been recorded in Nottingham since July, 1912. The first case during 1921, in an unvaccinated girl 20 years of age, had its onset about February 16. The infection was acquired in a northern town. The patient was removed to the isolation hospital, and there was no spread of the disease. The next case appeared May 22. It was suspected that the source of this infection was the Long Eaton outbreak, which was in progress at that time. Long Eaton is less than 7 miles from Nottingham, and communication between the towns is free and constant. From the middle of May, 1921, until the latter part of January, 1922, there occurred in Nottingham 112 cases.

The disease was of mild type, a large proportion of the cases being described as of the "alastrim" or western type; yet it is stated that from the same strain there developed other cases of normal unattenuated variety. Several cases were extremely severe, but there was no fatality.

The protection against the complaint afforded by vaccination is indicated in the following table, which shows the cases in age groups among the vaccinated and unvaccinated. It is stated that the somewhat extended period of protection is probably explained by the low infectivity of an attenuated virus.

Smallpox in Nottingham, Februcry, 1921, to January, 1922—Cases among vaccinated and unvaccinated arranged in age groups.

Vaccinated.						Unvaccinated.					
Under 10.	10 to 20.	20 to 30.	30 to 40.	40 to 50.	Over 50.	Under 10.	10 to 20.	20 to 30.	30 to 40.	40 to 50.	Over 50.
.....	9	5	7	50	25	12	2	1	2

All vaccinated persons attacked were over 30 years of age, whereas 87 out of 92, or 94.6 per cent, of the unvaccinated persons attacked were under 30 years of age.

It was stated that about half of the children of the city had been vaccinated and that none of those vaccinated contracted smallpox.

HEALTH DEPARTMENT PRACTICE OF LARGE AMERICAN CITIES.²

The need of authentic information on the practice of municipal health departments of American cities has long been recognized. A

¹ From a report by Philip Boobbyer, M. D., medical officer of health, city of Nottingham, in *The Medical Officer* for Apr. 1, 1922, p. 137.

² First Report of the Committee on Municipal Health Department Practice of the American Public Health Association, presented at the annual meeting of the association in New York City, November, 1921. Reprinted from the *American Journal of Public Health*, Vol. XII, Nos. 1 and 2, January and February, 1922.

great variety of procedures exists; the organization of health departments differs widely in different communities; the amount of money per capita spent on different branches of public-health work varies; and in other respects few standards are available for health officers who would pattern their departments after the best practice of American cities in order to achieve the best results.

In 1920 a committee was appointed by the American Public Health Association to carry out surveys and collect data on the current methods in large cities. The Metropolitan Life Insurance Co., the American Red Cross, and the United States Public Health Service cooperated in the work, which was done during 1920 and 1921. The committee consisted of the following members:

- Prof. C.-E. A. Winslow (chairman), New Haven, Conn.
- Dr. Charles V. Chapin, Providence, R. I.
- Dr. Wade H. Frost, Washington, D. C.
- Dr. Donald B. Armstrong, Framingham, Mass.
- Dr. Allen W. Freeman, Columbus, Ohio.
- Dr. Lewis R. Thompson, Washington, D. C.
- Dr. Louis I. Dublin (secretary), New York City, N. Y.

The inquiry was limited to cities having a population of 100,000 or over according to the census of 1920, although a few smaller cities, in which the health activities justified it, were included. The survey covers a total of 83 cities.

The committee presents a summary of its findings under the following main divisions:

- I. The Health Board and the Health Officer.
- II. Expenditures of Health Departments.
- III. Control of Communicable Diseases.
- IV. Tuberculosis.
- V. Venereal Diseases.
- VI. Infant Hygiene.
- VII. School Medical Inspection.
- VIII. Industrial Hygiene.
- IX. Special Clinics.
- X. Public Health Nursing.
- XI. Public Health Laboratory.
- XII. Milk Inspection.
- XIII. Food and Drug Inspection.
- XIV. Sanitary Inspection and Sanitation.
- XV. Water Supply.
- XVI. Sewerage and Sewage Disposal.
- XVII. Publicity and Public Health Education.
- XVIII. Vital Statistics.

The section on control of communicable diseases reports under the following heads: (1) Organization; (2) Notification; (3) Investiga-

tion and verification of cases; (4) Isolation; (5) Hospitalization; (6) Placarding; (7) Isolation period; (8) Terminal disinfection; (9) Control of contacts.

A striking feature in regard to the control of communicable diseases is the diversity of practice which leads to completely different methods of isolating the same disease in different communities. Hospitalization of communicable diseases is relatively incomplete in most cities. Two-thirds of the cities reporting still practice terminal fumigation, and many of the cities do not use available cultural methods for control of contacts.

As regards notification, typhoid fever, diphtheria, smallpox, scarlet fever, epidemic cerebrospinal meningitis, and poliomyelitis are reportable in all of the 83 cities. Mumps is not reportable in 4 cities, chicken pox is not reportable in 2, influenza not reportable in 5, pneumonia not reportable in 9, and malaria not reportable in 20 cities. Hookworm disease appears to be reportable in all of the southern cities but 4. The reporting of cases of tuberculosis is still exceedingly lax. Out of 66 cities for which data were secured on this point, 9 report less than 1 case per annual death, 28 report between 1 and 2 cases per death, 20 between 2 and 3 cases per death, and 9 more than 3 cases per death annually. It is stated that the best cities in this regard are Chicago, Flint, and Schenectady, with 4.1, 4.4, and 4.8 cases per death, respectively.

The information contained in this preliminary report of the committee should be of interest to all municipal health officers. The pamphlet may be had from the American Public Health Association for 20 cents a copy. A more complete report is to be published in book form and will be issued sometime during the latter part of 1922.

COURT DECISIONS.

TEACHER ENTITLED TO SALARY WHEN SCHOOL IS CLOSED DURING EPIDEMIC.

The Supreme Court of Illinois has decided¹ that where a school was closed by order of the State board of health on account of an influenza epidemic a teacher may recover her salary for the time during which the school was closed, the teacher being ready, able, and willing to teach and there being no provision in the contract covering such a contingency.

In this connection reference is made to the note on the case of Gregg School Tp., Morgan County *v.* Hinshaw, 132 N. E. 586, published in the Public Health Reports of February 3, 1922, page 240.

¹ Phelps *v.* School Dist. No. 109, Wayne County, 134 N. E. 312.